FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041889

Facility Name: CARE CENTRE OF CHAMPAIGN

Address: 1915 S. MATTIS (Number) CHAMPAIGN (City) 61821 (Zip Code)

County: COUNTY

Telephone Number: (847) 674-4700 **Fax #** (847) 674-4733

IDPA ID Number: 36-4082499

Date of Initial License for Current Owners: 6/1/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) BRADLEY ALTER
(Title) SECRETARY

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	118	Skilled (SNF)	118	43,070	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	118	TOTALS	118	43,070	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,827	1,827	8
9	SNF/PED					9
10	ICF	22,905	1,963	222	25,090	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,905	1,963	2,049	26,917	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.50%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/01/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/01/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 12 and days of care provided 1,827

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	143,328	755	5,184	149,267		149,267		149,267			1
2	Food Purchase		107,334		107,334		107,334	(384)	106,950			2
3	Housekeeping	92,058	32,922		124,980		124,980	320	125,300			3
4	Laundry	32,888	9,414	382	42,684		42,684		42,684			4
5	Heat and Other Utilities			78,541	78,541		78,541		78,541			5
6	Maintenance	32,399	13,859	12,569	58,827		58,827	56	58,883			6
7	Other (specify):*			4,992	4,992		4,992		4,992			7
8	**TOTAL General Services**	300,673	164,284	101,668	566,625		566,625	(8)	566,617			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	955,228	44,196	52,518	1,051,942		1,051,942	13,215	1,065,157			10
10a	Therapy	33,443	861	3,031	37,335		37,335		37,335			10a
11	Activities	42,808	2,309		45,117		45,117		45,117			11
12	Social Services	24,935			24,935		24,935		24,935			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,056,414	47,366	64,549	1,168,329		1,168,329	13,215	1,181,544			16
	C. General Administration											
17	Administrative	76,763		23,880	100,643		100,643	8,109	108,752			17
18	Directors Fees											18
19	Professional Services			75,773	75,773		75,773	(41,214)	34,559			19
20	Dues, Fees, Subscriptions & Promotions			13,562	13,562		13,562	(3,506)	10,056			20
21	Clerical & General Office Expenses	37,486	17,713	128,782	183,981		183,981	(47,950)	136,031			21
22	Employee Benefits & Payroll Taxes			273,993	273,993		273,993	17,588	291,581			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,523	2,523		2,523	2,147	4,670			24
25	Other Admin. Staff Transportation			1,193	1,193		1,193	4,198	5,391			25
26	Insurance-Prop.Liab.Malpractice			86,410	86,410		86,410	1,824	88,234			26
27	Other (specify):*			2,551	2,551		2,551	(2,551)				27
28	**TOTAL General Administration**	114,249	17,713	608,667	740,629		740,629	(61,355)	679,274			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,471,336	229,363	774,884	2,475,583		2,475,583	(48,148)	2,427,435			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: CARE CENTRE OF CHAMPAIGN #0041889 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	5,184	
	REPAIRS & MAINTENANCE		0	
			0	5,184
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		382	
			0	382
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		13,615	
	ELECTRICITY		39,434	
	WATER		24,985	
	CABLE TV - LOBBY		507	
			0	78,541
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		4,029	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		324	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		6,895	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		362	
	FIRE SERVICE		959	
			0	
			0	
			0	12,569
7	**OTHER**			
	SCAVENGER		4,992	
	SECURITY SERVICE		0	4,992
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	9,000	9,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	45,750	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	5,294	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	574	
	PHARMACY CONSULTANT	XVIII B 39-2	900	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	52,518
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES			
	OCCUPATIONAL THERAPY SERVICES			
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	2,293	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	563	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	175	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	3,031
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN #0041889 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	23,880	23,880
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	6,052	
	ADMINISTRATIVE CONSULTANTS	XIX C	41,333	
	PROFESSIONAL FEES	XIX C	28,388	
			0	75,773
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	3,430	
	EMPLOYEE WANT ADS	XIX F	3,746	
	CONTRIBUTIONS	VI 20 XIX F	100	
	DUES & SUBSCRIPTIONS	XIX F	2,358	
	LICENSES & PERMITS	XIX F	3,928	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	13,562
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		100,470	
	PENALTIES / OVERDRAFT CHARGES	VI 18	14,178	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		3,011	
	TELEPHONE		9,549	
	MESSENGER SERVICE		1,574	
			0	128,782

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	111,387	
	UNEMPLOYMENT COMPENSATION	XIX D	19,179	
	WORKERS COMPENSATION INSURANCI	XIX D	65,005	
	HOSPITALIZATION INSURANCE	XIX D	75,995	
	EMPLOYEE BENEFITS - OTHER	XIX D	26	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	2,401	
	CHICAGO HEAD TAX	XIX D	0	273,993
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	402	
	TRAVEL	XIX G	2,121	
			0	
			0	2,523
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		1,193	1,193
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		86,410	86,410
27	**OTHER**			
	BAD DEBTS	VI 24	2,551	
			0	2,551

GRAND TOTAL COLUMN 3 OTHER 774,884

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN #0041889 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			31,372	31,372		31,372	(8,566)	22,806			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			54,845	54,845		54,845		54,845			32
33	Real Estate Taxes			40,534	40,534		40,534		40,534			33
34	Rent-Facility & Grounds			436,365	436,365		436,365	5,678	442,043			34
35	Rent-Equipment & Vehicles			2,025	2,025		2,025	294	2,319			35
36	Other (specify):* STORAGE			1,020	1,020		1,020		1,020			36
37	**TOTAL Ownership**			566,161	566,161		566,161	(2,594)	563,567			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		44,136	11,314	55,450		55,450		55,450			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			64,605	64,605		64,605		64,605			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		44,136	75,919	120,055		120,055		120,055			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,471,336	273,499	1,416,964	3,161,799		3,161,799	(50,742)	3,111,057			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(10,516)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(384)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(14,178)	21		18
19	Entertainment		20		19
20	Contributions	(100)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,551)	27		24
25	Fund Raising, Advertising and Promotional	(3,430)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (31,159)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(19,583)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (19,583)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (50,742)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

CARE CENTRE OF CHAMPAIGN

ID# 0041889

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 0	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(384)	0	0	0	0	0	0	0	0	0	0	(384)	2
3	Housekeeping	0	0	320	0	0	0	0	0	0	0	0	320	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	56	0	0	0	0	0	0	0	0	56	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(384)	0	376	0	0	0	0	0	0	0	0	(8)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	13,215	0	0	0	0	0	0	0	0	13,215	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	13,215	0	0	0	0	0	0	0	0	13,215	16
	C. General Administration													
17	Administrative	0	(23,880)	31,989	0	0	0	0	0	0	0	0	8,109	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(41,333)	119	0	0	0	0	0	0	0	0	(41,214)	19
20	Fees, Subscriptions & Promotions	(3,530)	0	24	0	0	0	0	0	0	0	0	(3,506)	20
21	Clerical & General Office Expenses	(14,178)	(100,470)	66,698	0	0	0	0	0	0	0	0	(47,950)	21
22	Employee Benefits & Payroll Taxes	0	0	17,588	0	0	0	0	0	0	0	0	17,588	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	2,147	0	0	0	0	0	0	0	0	2,147	24
25	Other Admin. Staff Transportation	0	0	4,198	0	0	0	0	0	0	0	0	4,198	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,824	0	0	0	0	0	0	0	0	1,824	26
27	Other (specify):*	(2,551)	0	0	0	0	0	0	0	0	0	0	(2,551)	27
28	**TOTAL General Administration**	(20,259)	(165,683)	124,587	0	0	0	0	0	0	0	0	(61,355)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(20,643)	(165,683)	138,178	0	0	0	0	0	0	0	0	(48,148)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(10,516)	0	1,950	0	0	0	0	0	0	0	0	(8,566)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	5,678	0	0	0	0	0	0	0	0	5,678	34
35	Rent-Equipment & Vehicles	0	0	294	0	0	0	0	0	0	0	0	294	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(10,516)	0	7,922	0	0	0	0	0	0	0	0	(2,594)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(31,159)	(165,683)	146,100	0	0	0	0	0	0	0	0	(50,742)	45

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULT		CERTIFIED HEALTI	SKOKIE	BOOKKEEPING/M

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 23,880	CERTIFIED HEALTH MANAGEMENT		$	$ (23,880)	1
2	V	21	BOOKKEEPING	100,470				(100,470)	2
3	V	19	ADMIN CONSULTING FEES	41,333				(41,333)	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 165,683			$	$ * (165,683)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	CERTIFIED HEALTH MANAGEMENT		$ 320	$ 320	15
16	V	5	ELECTRIC & GAS		" " "				16
17	V	6	MAINTENANCE		" " "		56	56	17
18	V	10	NURSING/MEDICAL RECORDS		" " "		13,215	13,215	18
19	V	17	ADMIN SALARIES		" " "		31,989	31,989	19
20	V	19	PROFESSIONAL FEES		" " "		119	119	20
21	V	20	FEE, SUBSCRIPTIONS		" " "		24	24	21
22	V	21	OFFICE EXP.		" " "		66,698	66,698	22
23	V	22	EMPLOYEE BENEFITS		" " "		17,588	17,588	23
24	V	24	TRAVEL/SEMINAR		" " "		2,147	2,147	24
25	V	25	TRANSPORTATION		" " "		4,198	4,198	25
26	V	26	INSURANCE		" " "		1,824	1,824	26
27	V	30	DEPRECIATION		" " "		1,950	1,950	27
28	V	32	INTEREST		" " "				28
29	V	34	OFFICE RENT		" " "		5,678	5,678	29
30	V	35	EQUIPMENT RENTAL		" " "		294	294	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 146,100	$ * 146,100	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BRADLEY ALTER		ADMINISTRATION		SCHEDULE ATTACHED			SALARY	$ 20,487	17-3	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 20,487		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CERTIFIED HEALTH MANAGEMENT
Street Address: 3856 OAKTON SUITE 200
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((847) 674-4700
Fax Number: ((847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PER PATIENT DAY	252,049	8	$ 3,000	$	26,917	$ 320	1
2	5	ELECTRIC & GAS	" " "	252,049	8			26,917	0	2
3	6	MAINTENANCE	" " "	252,049	8	520		26,917	56	3
4	10	NURSING/MEDICAL RECORDS	" " "	252,049	8	123,747	123,747	26,917	13,215	4
5	17	ADMIN SALARIES	" " "	252,049	8	299,543	299,543	26,917	31,989	5
6	19	PROFESSIONAL FEES	" " "	252,049	8	1,116		26,917	119	6
7	20	FEE, SUBSCRIPTIONS	" " "	252,049	8	225		26,917	24	7
8	21	OFFICE EXP.	" " "	252,049	8	624,560	542,222	26,917	66,698	8
9	22	EMPLOYEE BENEFITS	" " "	252,049	8	164,697		26,917	17,588	9
10	24	TRAVEL/SEMINAR	" " "	252,049	8	20,108		26,917	2,147	10
11	25	TRANSPORTATION	" " "	252,049	8	39,310		26,917	4,198	11
12	26	INSURANCE	" " "	252,049	8	17,081		26,917	1,824	12
13	30	DEPRECIATION	" " "	252,049	8	18,257		26,917	1,950	13
14	32	INTEREST	" " "	252,049	8	0		26,917	0	14
15	34	OFFICE RENT	" " "	252,049	8	53,167		26,917	5,678	15
16	35	EQUIPMENT RENTAL	" " "	252,049	8	2,754		26,917	294	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,368,085	$ 965,512		$ 146,100	25

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BANK FINANCIAL		X	WORKING CAPITAL				377,119			10,251	6
7	SHAREHOLDERS	X		WORKING CAPITAL				744,000			43,320	7
8	AICC		X	INS FINANCING							1,274	8
9	TOTAL Facility Related						$	$ 1,121,119			$ 54,845	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 1,121,119			$ 54,845	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* **Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

** **If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 38,708	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 39,229	2
3. Under or (over) accrual (line 2 minus line 1).		$ 521	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 40,013	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 40,534	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	36,251	8
	1999	36,193	9
	2000	37,086	10
	2001	37,948	11
	2002	39,229	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 102% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CARE CENTRE OF CHAMPAIGN COUNTY COUNTY

FACILITY IDPH LICENSE NUMBER 0041889

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	45-20-22-282-005	NURSING HOME	$ 39,229.00	$ 39,229.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 39,229.00	$ 39,229.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,000 B. General Construction Type: Exterior CONCRETE Frame STEEL Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ROOFING			1996	9,253	237	39	237		1,748	9
10	SIDEWALK & PATIO			1996	4,146	276	15	276		2,005	10
11	DOOR INSTALLED			1996	636	16	39	16		114	11
12	HANDRAIL &BUMPER GUARD			1997	2,620	67	39	67		410	12
13	FLOOR TILES & CARPETS			1997	19,732	506	39	506		3,057	13
14	FLOORING, WALLPAPER, CEILING REPAIR			1998	13,669	350	39	350		2,045	14
15	ELECTRICAL WORK			1998	7,500	192	39	192		1,080	15
16	LANDACAPING			1998	11,551	770	15	770		4,235	16
17	DRYWALL/CEILING REPAIR			1999	3,860	99	39	99		483	17
18	ROOF REPAIR			1999	3,109	80	39	80		377	18
19	SIDEWALK REPAIR			1999	4,023	268	15	268		1,206	19
20	ROOF REPAIR			2000	10,000	364	27.5	364		1,380	20
21	WALLPAPER			2000	2,440	349	7	349		1,645	21
22	WALL/CEILING REPAIR			2000	1,425	52	27.5	52		188	22
23	CURCUIT BREAKERS			2000	710	26	27.5	26		78	23
24	WALLPAPER/HANDRAILS			2001	7,050	256	27.5	256		640	24
25	FLOOR TILE			2001	1,711	62	27.5	62		155	25
26	FLOOR BASE/WALLPAPER			2001	1,446	53	27.5	53		132	26
27	KICKPLATES			2001	995	36	27.5	36		90	27
28	HVAC UNIT			2001	3,162	115	27.5	115		257	28
29	ROOF REPLACEMENT-PARTIAL			2002	25,450	925	27.5	925	0	1,388	29
30	DOME ROOF REPAIR			2002	6,750	245	27.5	245	0	368	30
31	ENTRANCE DOORS			2002	4,193	152	27.5	152	0	228	31
32	LINTEL REPLACEMENT-OUTSIDE			2002	7,500	273	27.5	273	(0)	409	32
33	LINTEL REPLACEMENT-INSIDE			2002	1,800	65	27.5	65	0	98	33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	BLINDS DINING ROOM/HALLWAYS	2003	$ 6,370	$ 319	5	$ 637	$ 318	$ 637	37
38	ROOF REPLACEMENT	2003	35,900	538	27.5	653	115	653	38
39	DRYWALL REPLACEMENT RES ROOMS	2003	2,650	48	27.5	48	0	48	39
40	ALARM SYSTEM	2003	1,895	34	27.5	34	0	34	40
41	FLOORING	2003	7,859	143	27.5	143	(0)	143	41
42	DINING ROOM TABLES/CHAIRS	2003	17,537	319	27.5	319	(0)	319	42
43	KITCHEN FLOORING	2003	1,358	25	27.5	25	(0)	25	43
44	ALARM SYSTEM	2003	1,605	29	27.5	29	0	29	44
45	GREASETRAP IN KITCHEN FLOOR	2003	2,850	52	27.5	52	(0)	52	45
46	WALL AIR CONDITIONERS	2003	1,833	33	27.5	33	0	33	46
47	ALARM SYSTEM	2003	2,698	49	27.5	49	0	49	47
48	BLINDS DINING ROOM/HALLWAYS								48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 237,286	$ 7,423		$ 7,858	$ 435	$ 25,840	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 120,199	$ 13,446	$ 12,020	$ (1,426)	10 YRS	$ 59,606	71
72	Current Year Purchases	19,492	10,500	975	(9,525)	5 YRS	975	72
73	Fully Depreciated Assets							73
74	RELATED PARTY		1,953	1,953				74
75	TOTALS	$ 139,691	$ 25,899	$ 14,948	$ (10,951)		$ 60,581	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 376,977	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 33,322	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 22,806	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (10,516)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 86,420	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: CARE CENTER OF CHAMPAIGN

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		118	6/1/96	$ 436,365	25		3
4	Additions							4
5								5
6								6
7	TOTAL		118		$ 436,365 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: [ ] YES [ ] NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning 6/1/96
Ending 5/31/21

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/04	$ 446,859
13.	12/31/05	$ 457,353
14.	12/31/06	$ 467,696

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 2,025 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19			N/A		19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 3,938	$		$ 3,938	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			2,788			2,788	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			4,588			4,588	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				36,123		36,123	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MEDICAL SUPPLIES Other (specify): LAB	39-2 39-2					6,976 1,037		6,976 1,037	13
14	TOTAL			$		$ 11,314	$ 44,136		$ 55,450	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 118,000)	442,614		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,069		6
7	Other Prepaid Expenses	535		7
8	Accounts Receivable (owners or related parties)	437,676		8
9	Other(specify): R/E TAX ESCROW	30,757		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 938,651	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	237,286		15
16	Equipment, at Historical Cost	147,048		16
17	Accumulated Depreciation (book methods)	(133,933)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): OPTION DEPOSIT	345,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 595,401	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,534,052	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 141,325	$	26
27	Officer's Accounts Payable	744,000		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	451,863		29
30	Accrued Salaries Payable	3,782		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,764		31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,013		32
33	Accrued Interest Payable	242,733		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,630,480	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,630,480	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (96,428)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,534,052	$	48

*(See instructions.)

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 104,827	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 104,827	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(201,255)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (201,255)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (96,428)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,892,483	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,892,483	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	65,795	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 65,795	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	981	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 981	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	54	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 54	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNTS	20	28
28a	VENDING COMMISSIONS	1,211	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,231	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,960,544	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	566,625	31
32	Health Care	1,168,329	32
33	General Administration	740,629	33
	B. Capital Expense		
34	Ownership	566,161	34
	C. Ancillary Expense		
35	Special Cost Centers	55,450	35
36	Provider Participation Fee	64,605	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,161,799	40
41	**Income before Income Taxes (line 30 minus line 40)****	(201,255)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (201,255)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 55,850	$ 26.85	1
2	Assistant Director of Nursing	2,772	2,914	51,974	17.84	2
3	Registered Nurses	4,548	4,691	95,991	20.46	3
4	Licensed Practical Nurses	9,222	9,531	160,922	16.88	4
5	Nurse Aides & Orderlies	45,760	45,846	519,470	11.33	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,542	1,721	33,443	19.43	8
9	Activity Director	2,200	2,372	23,603	9.95	9
10	Activity Assistants	2,631	2,722	19,205	7.06	10
11	Social Service Workers	1,932	2,292	24,935	10.88	11
12	Dietician					12
13	Food Service Supervisor	2,056	2,080	35,500	17.07	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,171	7,633	68,446	8.97	15
16	Dishwashers	5,549	5,565	39,382	7.08	16
17	Maintenance Workers	2,082	2,241	32,399	14.46	17
18	Housekeepers	11,014	11,470	92,058	8.03	18
19	Laundry	4,477	4,669	32,888	7.04	19
20	Administrator	1,997	2,080	44,709	21.49	20
21	Assistant Administrator	2,000	2,080	32,054	15.41	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,975	2,309	37,486	16.23	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,033	2,153	24,235	11.26	31
32	Other Health C: Care Plan Coord	1,797	2,080	46,786	22.49	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	114,838	118,529	$ 1,471,336 *	$ 12.41	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	115	$ 5,184	1-3	35
36	Medical Director	MONTHLY	9,000	9-3	36
37	Medical Records Consultant	18	574	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	MONTHLY	900	10-3	39
40	Physical Therapy Consultant	46	2,293	10a-3	40
41	Occupational Therapy Consultant	11	563	10a-3	41
42	Respiratory Therapy Consultant	4	175	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant		0	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	194	$ 18,689		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	293	$ 12,378	10-3	50
51	Licensed Practical Nurses	984	33,093	10-3	51
52	Nurse Aides	13	279	10-3	52
53	TOTAL (lines 50 - 52)	1,290	$ 45,750		53

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
RENEE THOMPSON	ADMIN	0	$ 44,709
BREDNA DIVELY	ASST ADMIN	0	32,054
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 76,763

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 23,880
TOTAL (agree to Schedule V, line 17, col. 3)	$ 23,880
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		75,773
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 75,773

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 65,005
Unemployment Compensation Insurance		19,179
FICA Taxes		111,387
Employee Health Insurance		75,995
Employee Meals		#REF!
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		26
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		2,401
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
RELATED PARTY		17,588
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ #REF!

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,746
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	3,430
TRUST/FRANCHISE/CONTRIB/ETC	100
LICENSES & PERMITS	3,928
DUES & SUBSCRIPTIONS	2,358
MGMT CO ALLOCATION	24
TRUST/FRANCHISE/CONTRIB/ETC	(100)
Less: Public Relations Expense	(0)
Non-allowable advertising	(3,430)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,056

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	2,121
Seminar Expense	
	402
RELATED PARTY	2,147
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,670

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINTING/DECORATING		$		$	$	$	$	$	$	$	$	$
2													
3													
4					N/A								
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL HEALTHCARE ASSOC $2,360**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **64,605**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **#REF!** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees